

CONTACT REGISTRATION FORM
PLEASE PRINT CLEARLY AND COMPLETE CLIENT SECTION & SIGN BELOW

Today's Date: _____ **Site:** _____

Referrals: _____

Pregnant? Y N

Action Taken: _____

Health Dept. Use Only

CLIENT SECTION

(Patient's Name) **PLEASE PRINT**

Last _____ First _____ Middle _____

Birth Date _____ / _____ / _____ SSN _____

Home Address _____ Apt # _____

City _____ State _____ Zip _____

Phone(_____) _____ Cell Phone: _____

Race _____ Sex _____ Marital status _____ Physician/Provider Name _____

Provider Phone _____

Parent/Guardian _____ Parent Work Phone _____

HEALTH DEPARTMENT USE ONLY

Contact Association

 _____ Other _____

Prior Mantoux TST? Y N

If yes, Date: _____ Induration _____

Location where test was performed _____

Prior Treatment? Disease _____ LTBI _____

Meds Taken _____

Location of Treatment _____

TST #1 – Arm: _____ Left _____ Right _____
 Date Given _____ Time _____ Lot # _____
 Date Read _____ Time _____
 Induration _____ mm _____ Positive _____ Negative _____

Signature _____ Pos # _____

TST #2 – Arm: _____ Left _____ Right _____
 Date Given _____ Time _____ Lot # _____
 Date Read _____ Time _____
 Induration _____ mm _____ Positive _____ Negative _____

Signature _____ Pos # _____

TB Symptoms (Check all that apply)

_____ None
 _____ Cough > 3 weeks
 _____ Productive? Y N Hemoptysis? Y N
 _____ Fever, unexplained
 _____ Unexplained weight loss
 _____ Poor appetite _____ These symptoms
 _____ Night Sweats _____ should be evaluated
 _____ Fatigue _____ in context

**Additional Individual Risk for Infection
 (Check all that apply)**

_____ Foreign born-High Prevalence Country
 _____ List country _____
 _____ Resident/employee congregate setting
 _____ Medically underserved
 _____ Uses illegal drugs
 _____ Homeless within last 2 years

Individual Risk for Progression to Disease

_____ HIV infection
 _____ Medical conditions that increase risk
 (diabetes, ESRD, Cancer, 10% below ideal weight, etc.)
 _____ History of inadequate TB treatment
 _____ Immunosuppressive therapy (steroids, cancer
 treatment, include treatment for Rheumatoid
 Arthritis such as Remicade, Humira, etc.)

- I hereby authorize the doctors, nurse, or nurse practitioners of the Virginia Department of Health to administer the Tuberculin Skin Test (PPD) to me or my child named above.
- I agree that the results of this test may be shared with other health care providers.
- The Deemed Consent for blood borne diseases has been explained to me and I understand it.
- I acknowledge that I have received the Notice of Privacy Practices from the Virginia Department of Health.
- I understand that:
 - this information will be used by health care providers for care and for statistical purposes only.
 - this information will be kept confidential.
 - medical records must be kept for 5 years after death, 10 years after my last visit, or 4 years after the age 18 for any minor child.

X _____ Date _____